

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <u>LOIS</u>			First <u>M.</u> Middle <u>BIRTH</u> Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <u>4</u> Day <u>29</u> Year <u>1968</u>		2b. HOUR <u>M</u>		
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>4-19-1896</u>	6. AGE (In years last birthday) <u>72</u> YRS.	IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>	IF UNDER 24 HRS HOURS <u>  </u> MIN <u>  </u>	2c. DATE PRONOUNCED DEAD Month <u>4</u> Day <u>30</u> Year <u>1968</u>		2d. HOUR <u>M</u>		
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>CAROLINE</u>				
10. CITY OR TOWN OF DEATH <u>Denton</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>at home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b. COUNTY <u>TALBOT</u>		13c. CITY OR TOWN <u>SMITHSON</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <u>CHARLES</u> Middle <u>LAKE</u> Last <u>HARMON</u>			15. MOTHER'S MAIDEN NAME First <u>CORA</u> Middle <u>WILLOUGHBY</u> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16b. SOCIAL SECURITY NO. <u>151-01-5778</u>		17. INFORMANT <u>LESSER</u>		ADDRESS <u>715 BRYANT AVE ROSLYN HARBOR, N.Y.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>574.9</u> (b) <u>Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>574.8</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>William E. Latimer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-30-1968</u>		
EXAMINER'S NAME (Type) <u>William E. Latimer M.D.</u>		ADDRESS <u>  </u>		ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>MAY 3, 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City or Town) <u>EASTON</u> (County) <u>TALBOT</u> (State) <u>MD</u>				
24. FUNERAL DIRECTOR <u>Robert Buck</u>		ADDRESS <u>Easton, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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JAN 10 1968

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MAY 3 1968

# FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) <b>Edwin Morris Briscoe</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>14</b> Year <b>1968</b>			2b. HOUR <b>3:04</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-10-1914</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Caroline</b>			
10. CITY OR TOWN OF DEATH <b>Rural Greensboro</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>None</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Truck Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>						13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Greensboro</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME First <b>Samuel</b> Middle <b>Briscoe</b> Last <b>Briscoe</b>						15. MOTHER'S MAIDEN NAME First <b>Bessie D.</b> Middle <b>Morris</b> Last <b>Morris</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWII</b>				16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT ADDRESS <b>Samuel Briscoe Ridgely, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>890X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>9160</b> (b) <b>Smoke Inhalation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>?</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2/3 of body consumed by the fire</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month <b>8</b> Day <b>14</b> Year <b>1968</b> HOUR A.M. <b>4</b> P.M. <b>14</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Burned to death in Shanty</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Greensboro Home</b>		21f. LOCATION Street or R.F.D. No. <b>Greensboro</b> City or Town <b>Caroline</b> County <b>Maryland</b> State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Harold B. Plummer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>4/1/68</b>				
EXAMINER'S NAME (Type) <b>Harold B. Plummer M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-17-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillsboro</b>				23d. LOCATION (City or Town) (County) (State) <b>Hillsboro, Maryland</b>				
24. FUNERAL DIRECTOR <b>J.E. Boulais</b> ADDRESS <b>Greensboro, Maryland</b>						25a. REC'D BY REGISTRAR <b>APR 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>GEORGETA</b> First <b>BUTLER</b> Middle <b>Butler</b> Last		2a. DATE OF DEATH Month <b>APR</b> Day <b>24</b> Year <b>1968</b>		2b. HOUR M
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>AUG 23, 1878</b>	6. AGE (In years lost (Birth day) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>CHARLOTTE</b> Md.	
10. CITY OR TOWN OF DEATH <b>HOBBS</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>at home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>CHARLOTTE</b>	13c. CITY OR TOWN <b>HOBBS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>JAMES E.</b> Middle <b>LISTER</b> Last		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>CADEN</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>ALMER BUTLER</b> Address <b>DENTON MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Chronic Congestive Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic C.V. Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4221 Nutritional Anemia</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar. 5, 1966</b> , to <b>Apr. 24, 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Charles H. Stonesifer</b> DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Apr. 26 '68</b>
22d. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22e. ADDRESS <b>Greensboro, Md. 21639</b>		
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>APR. 27, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>	
24. FUNERAL DIRECTOR <b>J. V. GREGG MOORE</b> ADDRESS <b>DENTON MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>
23d. LOCATION (City or Town) (County) (State) <b>DENTON CO. MD.</b>				



Charles H. Thompson, M.D., President, 1913-1914

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Calvin Farris						April 18 Day 1968 Year		9P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		Feb. 25, 1902		66 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Alabama		U.S.A.				Caroline Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Rural Ridgely			None			Retired Farmer		Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Caroline		Ridgely		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		None	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
James Farris			No Record							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			163-07-1891		Jean Farris Ridgely, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) _____										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Arteriosclerotic C.V.Dis.										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)										
Chronic Obstructive Pulmonary Emphysema										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Mar. 5, 1965, to Apr. 19, 1968, that (I) (we) last saw the deceased alive on Apr. 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
Charles H. Stonesifer								Apr. 19 '68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Charles H. Stonesifer, M.D.					Greensboro, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		4-22-68		Lawncroft			Linwood, Penna.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. E. Boulaie, Greensboro, Md.					DATE APR 22 1968		Charles Judge			





FOR STATE  
HEALTH DEPT

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> <span>05449</span> <span>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</span> <span>05451</span> </div>											
1. DECEASED-NAME (Type or Print)			First DANA			Middle FISHELL			Last FISHELL		
3. SEX Male			4. RACE White		5. DATE OF BIRTH March 1, 1962		6. AGE (in years last birthday) 6 YRS.		7a. BIRTHPLACE (State or foreign country) Maryland		
7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> April 16 1968 15:45 PM			
10. CITY OR TOWN OF DEATH Federalsburg - Rural			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bridgeville Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY Public School		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.		
14. FATHER'S NAME David W. Fishell, Sr.			15. MOTHER'S MAIDEN NAME Martha M. Burklew			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None		
17. INFORMANT Mrs. David W. Fishell, Sr., Federalsburg, Md.			18. ADDRESS Federalsburg, Md.			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 4:20 P.M. 4/16/68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Riding bicycle in front of oncoming car			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Route 316 RFD Federalsburg Maryland East Caroline			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED 4/19/68			22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery			22d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland		
22b. DATE SIGNED 4/19/68			22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery			22d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 19, 1968			23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery			23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland		
23b. DATE April 19, 1968			23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery			23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland			24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland			25a. REC'D BY REGISTRAR DATE APR 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			25c. ADDRESS (Street, city, town, or county)		



2

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05450

05452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05450		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05452	
1. DECEASED-NAME (Type or print) <b>NORMAN</b> First Middle Last				2a. DATE OF DEATH <b>APR</b> Month <b>13</b> Year <b>1968</b>		2b. HOUR <b>704</b> M	
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>AUG 30, 1895</b>		6. AGE (In years last birthday) <b>72</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CISRO LINE</b> Md.	
10. CITY OR TOWN OF DEATH <b>DENTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) _____		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) _____		12b. KIND OF BUSINESS OR INDUSTRY _____	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>CAROLINE</b>		13c. CITY OR TOWN <b>DENTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER _____		14. FATHER'S NAME First Middle Last <b>GEORGE</b> <b>HARRIS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give year or dates of service) <b>WW2</b>		16b. SOCIAL SECURITY NO. <b>218-07-3589</b>		17. INFORMANT <b>Mrs. Elmore Thetford Denton</b> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardio-Vascular Disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) _____		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 1968, to <b>4/13</b> , 1968, that (I) (we) last saw the deceased alive on <b>4/11</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>W. A. Anderson</b> DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>4/16/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Wm. A. Anderson, M.D.</b>				22e. ADDRESS <b>Denton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>16 Apr 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>		23d. LOCATION (City or Town) (County) (State) <b>DENTON CISR. MD.</b>	
24. FUNERAL DIRECTOR <b>Charles J. Moore</b> ADDRESS <b>Denton</b>				25a. REC'D BY REGISTRAR <b>APR 18 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2000

1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <b>Mabel Ann Thompson</b>					2a. DATE OF DEATH Month Day Year <b>4 8 1968</b>			2b. HOUR <b>2P. M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 14, 1898</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Caroline</b> Md.				
10. CITY OR TOWN OF DEATH <b>Rural Marydel</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>None</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Marydel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>	
14. FATHER'S NAME First Middle Last <b>Elick Hall</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Jenny Whiteley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-30-9282</b>		17. INFORMANT Address <b>Howard Thompson Marydel, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the cecum</b> <b>1530</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1530</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9, 1966</b> , to <b>Apr. 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>Apr. 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Charles H. Stonesifer</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>Apr. 10, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer M.D.</b>		22e. ADDRESS <b>Greensboro, Md. 21639</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>			23d. LOCATION (City or Town) (County) (State) <b>Greensboro, Maryland</b>			
24. FUNERAL DIRECTOR <b>J.E. Boulais Greensboro, Md.</b>					25a. REC'D BY REGISTRAR <b>Apr 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



OFFICE OF THE SECRETARY OF THE ARMY

1914

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Thompson

Ann

Walter

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1914

July 1, 1914

White

Female

Caroline

U.S.A.

Female

June

Female

June

Female

X

Caroline

Id.

Female

Id.

21-50-100

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05452

05454

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First DELLA		Middle HARPER		Last TRIBBETT		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day 4 Year 1968		2b. HOUR 7:40	
3. SEX F	4. RACE W	5. DATE OF BIRTH MAR 11, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month 4 Day 15 Year 1968	
7a. BIRTHPLACE (State or foreign country) I		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CISROWNE				Md.	
10. CITY OR TOWN OF DEATH RURAL DENTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) at home		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CISROWNE		13c. CITY OR TOWN RURAL DENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME (UNKNOWN)		First (UNKNOWN)		Middle MOLLER		Last UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT EDEN TRIBBETT		ADDRESS DENTON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiac Decompensation DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes nos 10yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 443X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Harold B. Plummer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/16/68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE APR 17, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON CRR. MD.					
24. FUNERAL DIRECTOR CHARLES V. MOORE DENTON				ADDRESS		25a. REC'D BY REGISTRAR APR 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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RECEIVED BY THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First JOHN		Middle H.		Last WILLIAMS		2a. DATE OF DEATH Month Day Year April 12, 1968		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 26, 1900		6. AGE (In years lost birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Caroline		Md.			
10. CITY OR TOWN OF DEATH Federalsburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer & Salesman		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.			
14. FATHER'S NAME First Middle Last HARVEY E. WILLIAMS		15. MOTHER'S MAIDEN NAME First Middle Last MYRTLE THOMAS WILLIAMS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 216-12-1432		17. INFORMANT Address Mrs. Margaret Williams, Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic myocardial failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/16, 1967</u> to <u>4/12, 1968</u> , that (I) (we) last saw the deceased alive on <u>4/12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/15/68			
22d. PHYSICIAN'S NAME (Type) <u>Frank M. Anderson</u>		22e. ADDRESS <u>Federalsburg, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) Federalsburg, Caroline, Md.		(County) (State)			
24. FUNERAL DIRECTOR <u>Harvey Williams</u>		ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

05-1-10

UNITED STATES OF AMERICA

05-1-10

IN SENATE, January 1, 1910

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

ON MAY 1, 1899

AND A RESOLUTION PASSED BY THE HOUSE OF REPRESENTATIVES

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